Dear Parents/Guardians,

Smart Smiles is an oral health program that focuses on dental disease prevention. Oral care is provided at the school and serves students who are from low-income families, uninsured and/or Medicaid/CHIP enrollees. **There are no fees to the child or the family for our services**, but Medicaid/CHIP will be billed if eligible.

Your child will receive a dental examination by a dentist and an oral health assessment and preventive services by a dental hygienist. All restorative dental needs will be referred to your current dental home provider or a partnering community dental office/clinic. We recommend that your child/family be seen in a dental office/clinic every 6-12 months for a regular check-up.

Your child will receive one or more of the following preventative services: (1) dental exam/oral health assessment, (2) dental x-rays as needed, (3) dental cleaning, (4) dental sealant, (5) application of silver diamine fluoride if necessary, and (6) fluoride varnish.

A dental exam is preformed by a dentist either onsite at the school or via tele-dentistry methods (through computer/internet). The oral health assessment provides the dental hygienist with information that is used to determine treatment and oral health education to the child.

Dental x-rays are images that can show areas of the teeth and gums that are not visible during a regular exam. They can help confirm cavities or other infections in the teeth and bone.

A dental cleaning removes all the hard and soft material that forms on the child's teeth.

A dental sealant is a thin plastic coating painted on the chewing surfaces of the back teeth. They are bonded to the tooth to help prevent decay as your child grows.

Silver Diamine Fluoride is a solution that is placed in a cavity to stop decay. The solution *will turn the cavity black*, but will help the tooth from being destroyed by bacteria and decay.

Fluoride varnish is applied to strengthen teeth and help them be more resistant to decay.

To have your child participate in this program at school PLEASE complete the following information and consent form. This information is *CONFIDENTIAL*.

1) Number of parents and children in your family: _____

2) Monthly income: $_____

3) Do you have a IRC or CCS Caseworker? If so, please list their name: _____

4) Do you have any of the following? Circle YES or NO response

My child is on free and reduced lunch?	YES	NO
High school degree/GED?	YES	NO
A degree from a two-year college?	YES	NO
A degree with two or more years of college?	YES	NO

5) Does your child live with the following family member(s)? (Please check)

☐ Single parent/mother ☐ Both parents

☐ Single parent/father ☐ Other _____

Scanned_____

6) What is the primary language spoken in the home? _____

7) What is your current housing?

- ☐ Own
- ☐ Rent
- ☐ Homeless
- ☐ Other _____

8) What is your source of income?

- ☐ No income
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Supplemental Security Income (SSI)
- ☐ Social Security
- ☐ Pension
- ☐ General Assistance
- ☐ Employment only
- ☐ Employment + other
- ☐ Unemployment
- ☐ Other

Consent to Treatment

Please complete the following information so your child can participate in the Smart Smiles Oral Healthcare Program. The agreement is valid while child is in attendance at the school in which the information was collected, (up to 7 years) unless the parent requests in writing that the child not participate in the program any longer.

Yes, I do *want my child to participate in this program. I consent to and understand the following:*

- I understand that the treatment provided by a dental hygienist does not take the place of an exam by a dentist and that it is recommended is to see a dentist every 6-12 months for a regular check-up.
- I understand that my child will be seen for dental hygiene care during school hours and may miss some class time.
- I authorize a public health dental hygienist to assess the oral health and teeth of my child.
- I authorize a public health dental hygienist or trained dental/dental hygiene student to place dental sealants on the necessary teeth to help protect them from decay.
- I authorize all preventive dental services to include a dental cleaning (prophylaxis), fluoride varnish, dental x-rays (radiographs) of my child's teeth and sealants as necessary.
- I authorize the use of Silver Diamine Fluoride (SDF) to be placed if my child has a cavity. I understand this may stop the decay, but can turn the cavity black/brown.
- I agree to accept appointment reminders and other messages by phone.
- I allow my child's images to be used by Smart Smiles.
- I agree to take a satisfaction survey of the Smart Smiles Oral Healthcare Program
- I allow Smart Smiles to review my child's data for program evaluation and promotion.
- I agree not to hold Smart Smiles or it's partners liable for any negative reactions as a result of care received for my child or myself.
- If applicable, I approve the billing of Medicaid, CHIP, or dental insurance for the services provided.
- I agree to allow someone to contact me to assist with Medicaid/CHIP enrollment.
- I agree to allow my child to receive a referral for dental restorative treatment.
- I understand that it is my responsibility to follow up with any needed treatment for my child.

Parent/Guardian: _____
Please Print Name

Parent/Guardian: _____ Date: _____
Signature (**Required**)

Scanned_____

*Please initial if you **don't** want your child participating in the following:*

- ☐ **No, I do not** want my child to participate in this program because: _____
- ☐ **No, I do not** want my child to take a satisfaction survey.
- ☐ **No, I do not** want my child to have x-rays
- ☐ **No, I do not** want my child to have sealants
- ☐ **No, I do not** want my child to have fluoride
- ☐ **No, I do not** want my child's picture to be used by Smart Smiles.

Return forms to your child's teacher. Thank you!

HEALTH/DENTAL HISTORY

Name of child: _____ Date of birth: ____/____/____ Male/Female

Home address: _____

City: _____ Zip: _____

Name of Parent/Guardian: _____

Parent phone: _(_____)_____ Cell phone: _(_____)_____ Text? Y / N

Parent email: _____

School: _____ Grade: _____

Teacher: _____ Room#: _____

Student ID#: _____

Race:

- ☐ White/Caucasian
- ☐ Hispanic/Latino
- ☐ African American/Black
- ☐ Native Hawaiian/Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ Mixed Race
- ☐ Asian
- ☐ Other_____

Please answer to following questions to help us learn more about your child:

1. How often does your child see a dentist? (include orthodontist/oral surgeon)
   - ☐ 6 months – 1 year
   - ☐ more than 3 years
   - ☐ not regularly, only for emergencies
   - ☐ has never seen a dentist

   Name of Dentist: _____

If Yes, please describe:

2. Is your child experiencing oral pain (toothache, sore gums, etc.)?
   - ☐ No
   - ☐ Yes, _____

3. Does your child have Medicaid or CHIP?
   - ☐ No
   - ☐ Yes,

     Medicaid ID #_____ Child's name on card: _____

     CHIP ID #_____ Child's name on card: _____

(Please provide a copy of the insurance card)

Scanned_____

4. Does your child have other dental insurance?
   - ☐ No
   - ☐ Yes, Dental Insurance Name _____
     Policy Holder Name_____ Policy Holder Birthdate: ____/____/____
     Policy #_____ Group # _____

5. Has your child ever had a serious health problem/condition? (e.g. Asthma)
   - ☐ No
   - ☐ Yes, _____

6. Has your ever been taken to a hospital emergency room for a dental related emergency?
   - ☐ No
   - ☐ Yes, _____ Date: _____

7. Is there anything else we should know about your child prior to treatment?
   - ☐ No
   - ☐ Yes, _____

8. Is your child taking any medications?
   - ☐ No
   - ☐ Yes, _____

9. Does your child have any allergies (e.g. medicine, latex, nuts, etc.)?
   - ☐ No
   - ☐ Yes, _____

10. Does your child have anxiety related to dentists or doctors?
    - ☐ No
    - ☐ Yes, 1 2 3 4 5

(please rate: 1= mild, 5= severe)

Please share as much information as possible so we may provide the best care to your child.

Every child can participate in this program, regardless of health or the ability to pay.

Return forms to your child's teacher. Thank you!

Scanned_____